PRINTED: 10/15/2014
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0702	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	10/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA LAFOLLETTE HEALTH AND REHAB	200 TORREY ROAD LAFOLLETTE, TN 37766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 831 SS=E	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide fire protection by the elimination of fire hazards. The findings include: Observation and interview with the maintenance director on October 1, 2014 at 1:50 p.m. revealed an excessive accumulation of grease on the roof underneath the exhaust fans which creates a fire hazard. The maintenance director revealed that the grease accumulation on the roof would also cause damage to the rubber roof. (Reference tag K69) This finding was verified by the maintenance director and acknowledged by the assistant administrator during the exit conference on October 1st, 2014.	N 831	N831 1200-8-6-.08 (1) Building Standards 1. Current fans and roof were cleaned. 2. All residents have to potential to be affected. 3. Current exhaust fans will be replaced with hinged upblast exhaust fans. 4. Upblast exhaust fans will be placed on a monthly preventive maintenance inspections	10/3/14 11/15/14 11/15/14

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Dana Lloyd 11/14/14 Administrator

STATE FORM 6899 7CC521 If continuation sheet 1 of 1